EASTERN CAROLINA MEDICAL CENTER

MEDICAL RECORDS RELEASE

Patient's Full Name: ____
Any Other Names Patient May Be Listed As: ____________________________
Address:____
City, State, Zip:____
Date of Birth:____

I hereby request the following medical records in the possession of the provider:

FROM: Eastern Carolina Medical Center	TO: (name)
One Medical Drive	(address)
Benson, NC 27504	(address)
Phone: (919) 894-5787	Phone:
Fax: (919)	Fax:

Please check: (Within the last 2 years unless specified)

___ Complete Medical Record
___ Clinic Notes
___ Operative Reports
___ Pathology Reports
___ Ultrasound/X-Ray Reports
___ Emergency Reports
___ Lab Results
___ Pap Smear Results
___ Mammogram Reports
___ Discharge Summaries
___ Other: ____

For dates of treatment: (for example: specific date, range of dates, all dates of service)

____

Please initial if you do not want any of the following released:

___ Acquired Immunodeficiency Syndrome (AIDS)
___ Human Immunodeficiency Virus (HIV)
___ Behavioral Health Services/Psychiatric Care
___ Treatment for alcohol and drug abuse
___ Other: ____

The purpose of the disclosure is:

_____ Continued patient care ____ Other:______________________________________

Are you leaving the practice? _____ No ____ Yes (if yes, reason)________________________

This request is valid for 6 months from date of the above signature. I understand that I may change my mind and revoke this Medical Records Request in writing at any time. I understand that changing my mind will not affect my treatment. The revocation will not apply to the extent that Eastern Carolina Medical Center has already taken action where it relied on my permission. Once the information is released, it may no longer be protected by federal privacy regulations.

_________________________________ _________________________________
Patient Date Legal Representative (Relationship to Patient)

____
Witness Date